STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING _____ B. WING _____	C 10/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY	**559 W LONGEST ST PAOLI, IN 47454**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00155439. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 19, 2014. Complaint IN00155439 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 6 and 7, 2014 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Survey team: Dorothy Watts, RN-TC Terri Walters, RN Amy Wininger, RN Sylvia Scales, RN Census bed type: SNF: 11 SNF/NF: 80 Total :91 Census payor type: Medicare: 13 Medicaid: 71 Other: 7 Total: 91 Sample: 11 Paoli Health and Living was found to be in compliance with 42 CFR Part 483, Subpart B and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING _____ B. WING _____	C 10/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00155439. Quality review completed on October 9, 2014, by Janelyn Kulik, RN.	F 000		